Kansas Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
Authorization for Release of Protected Health Information

Member's Name (Last, First, MI)	**Employee ID or Social Security Number**

Please select the specific organization(s) that is/are authorized to provide the protected health information:

❑**Blue Cross Blue Shield** ❑**Coventry Health Care** ❑**UnitedHealthcare** ❑**Caremark Rx** ❑**Delta Dental** ❑**Superior Vision** ❑**SilverScript Part D** ❑**State Employee Health Plan**

Please select the specific person,organization, or class of persons authorizedto receive and use the protected health information:

❑**State Employee Health Plan** ❑**Other (please specify):** _____

Please describe in detail the protected health information you wish the SEHP to disclose:

Provider Name	**Date of Service**

Please state the purpose of the request below.

❑**At the request of the individual**

❑**At my request to review claims and explain the information**

❑**Other (please specify)**_____

Please state the date or event that this authorization will expire.

❑**One year from the date of this authorization**

❑**On the following date:**_____**, 20** ____

❑**In the event of:**_____

If no date or event is stated, this authorization will expire one year from the date of my signature.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the SEHP Compliance Officer in writing at 900 SW Jackson, Room 900-N, Topeka, KS 66612. I understand that the revocation is only effective after it is received and logged by the SEHP. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

I understand that I am entitled to receive a copy of this authorization.

The SEHP will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.

I hereby authorize the use or disclosure of my protected health information as described in this authorization.

_____ _____

Signature of Member or Personal Representative **Date**

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of: _____

This authorization reflects the requirements of 45 CFR & 164.508 (August 14, 2002)